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FILE COPY

June 15, 2006

Shirlee Farley, Administrator
Rosewind House
5815 Coffey Street
Garden City, ID 83714

Dear Ms. Farley:

On June 1, 2006, a complaint investigation survey was conducted at Rosewind House The survey was conducted by Polly Watt-Geier, L.S.W., and Frutoso Gonzalez, R.N. This report outlines the findings of our investigation.

Complaint #ID00001424

Allegation #1: An identified resident had a physician's order for support hose. The facility did not help her with them as ordered by her physician.

Findings: Based on observation, interview, and record review, it was determined that the identified resident had physician's orders for support hose. The facility did help her with them as ordered by her physician.

On May 31, 2006 at 3:15 p.m., the identified resident was observed to have knee high support hose on both lower extremities.

On May 31, 2006 at 3:15 p.m., the identified resident stated that the caregivers helped her put on the support hose in the morning and removed them at night.

Review of the identified resident's record on June 1, 2006 revealed physician orders dated April 14, 2006, which documented that the resident was to wear knee high support hose daily.

Further review of the record revealed a negotiated service agreement (NSA) dated December 1, 2005, which documented that the facility would direct caregivers to assist the resident put on her support hose daily.

On June 1, 2006 at 10:45 a.m., the administrator stated that the facility assisted the resident with her support hose as directed by the physician.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation survey conducted on June 1, 2006.

Allegation #2: The facility gave an identified resident a wheelchair to use. The wheelchair did not have brakes, which resulted in the resident falling. The resident laid on the floor for at least a half hour before staff found her.

Findings: Based on observation, interview, and record review, it was determined that the wheelchair the facility gave to the identified resident for her to use had brakes. The resident denied ever falling out of the wheelchair.

Review of the facility incident and accident reports from March 2006 to May 2006 revealed no documented evidence that a resident fell out of a wheelchair.

Observation of the resident's room on May 31, 2006 at 3:15 p.m. revealed a wheelchair. The wheelchair had hand brakes that could be locked easily and securely.

On May 31, 2006 at 3:15 p.m., the identified resident stated that she had no problems with the brakes on the wheelchair. She said that the brakes had worked since the day the wheelchair was brought for her to use. She denied ever falling out of the wheelchair because of faulty brakes.

On June 1, 2006 at 10:45 a.m., the administrator stated that she was not aware of an instance where a resident fell out of a wheelchair because of faulty or no brakes.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation survey conducted on June 1, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Virginia Loper RN

FRUTOSO GONZALEZ, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

FG/sm
c: Virginia Loper, R.N., Supervisor, Residential Community Care Program